Psychological Testing

Agency Name

Agency Address

Identifying Information

Name: Age:

Ethnicity: Gender:

Medicaid Number:

Individual(s) present:

Service Rendered:

Setting of Service:

Testing Start Time: End Time: Duration:

Interpretation Start Time: End Time: Duration:

Transcription Start Time: End Time: Duration:

Service Provider:

Date of Report:

Assessment Protocol

Chief Complaint/History of present illness

Brief History

Tests Administered

Test Scores

Evaluation of Test Results

Current Functioning Of The Individual

Diagnostic Impression

DSM V diagnosis (including codes and specifiers)

Prognosis

Specific Treatment Recommendations for Behavioral Health and other Services as appropriate.

Signature: Date:

Include credential and title

Clinical Supervisor Signature: Date:

Include credential and title
(If Necessary)